otogenetics® corporation

Carrier Screening Test Requisition Gx™

LABORATORY USE ONLY:	DATE & TIME RECEIVED:	ACCESSION NO:	SPECIMEN ID:

1. PATIENT INFORMATION (REQUIRED)

First Name_____ Last Name_____
DOB(mm/dd/yyyy) _____ ☐Male ☐Female Age_____
Address_____
City_____ State_____ Zip Code _____
Phone _____ Email_____

2. PATIENT PAYMENT OPTIONS

☐ **INSURANCE:** Please attach a copy of front and back of insurance card and **Complete the reverse side of this form**

☐ **SELF-PAY:** Otogenetics will contact patient to obtain payment

☐ **INVOICE PRACTICE / INSTITUITIONAL BILL / FACILITY BILL**

3. ORDERING PHYSICIAN INFORMATION (REQUIRED)

First Name_____ Last Name_____
Medical Credentials_____ NPI#_____
Facility Name_____
Address_____
City_____ State_____ Zip_____
Direct Office Contact_____
Phone_____

4. ADDITIONAL RESULTS RECIPIENT

Healthcare Professional Name _____
Phone_____ Fax_____
Email (for notification of results only)_____

5. SPECIMEN INFORMATION (REQUIRED)

Date of Collection_____ Collected By_____
Specimen Type ☐ Saliva ☐ Blood (Lavender Top)

6. ETHNICITY

Patient		Partner (Biological Father of Baby)	
☐ African/African American	☐ Hispanic/Latin American	☐ African/African American	☐ Hispanic/Latin American
☐ Ashkenazi Jewish	☐ Mediterranean	☐ Ashkenazi Jewish	☐ Mediterranean
☐ Caucasian	☐ Sephardic Jewish	☐ Caucasian	☐ Sephardic Jewish
☐ East Asian	☐ South East Asian	☐ East Asian	☐ South East Asian
☐ French Canadian	☐ Other	☐ French Canadian	☐ Other

7. CARRIER SCREENING

☐ **Basic 5 with CF** Alpha-Thalessemia, Beta Hemoglobinopathies (Beta-Thalassemia and Sickle Cell), Cystic Fibrosis, Duchenne/Becker Muscular Dystrophy, Spinal Muscular Atrophy **Z13.228, Z13.0**

☐ **ACOG/ACMG 13 with CF** Alpha-Thalessemia, Beta Hemoglobinopathies (Beta-Thalassemia and Sickle Cell), Bloom Syndrome, Canavan Disease, Cystic Fibrosis, Duchenne/Becker Muscular Dystrophy, Familial Dysautonomia, Fanconi Anaemia, Gaucher Disease, Mucolipidosis IV, Niemann-Pick Disease, Types A and B, Spinal Muscular Atrophy, Tay-Sachs Disease **Z13.228, Z13.0**

☐ **Ashkenazi Jewish Diseases 38**

☐ **Pan-Ethnic 167**

☐ **Clinical Exome Sequencing** ☐ **Other**_____

8. SELECT ICD10 DIAGNOSIS CODE (S)

☐ Z13.228 Encounter for screening for other metabolic disorders
☐ Z84.81 Family history of carrier of genetic disease
☐ Z84.89 Family history of other specified conditions
☐ Z81.0 Family history of intellectual disabilities
☐ Z82.69 Family history of other diseases of the musculoskeletal system and connective tissue
☐ Z13.71 Non-procreative screening for genetic disease carrier status
☐ Z13.79 Other screening for genetic and chromosomal anomalies
☐ Z13.89 Screening for other disorder(s)
☐ Z31.5 Encounter for genetic counseling
☐ Other ICD10 Code

9. INDICATIONS FOR CARRIER TESTING

Is Patient Female or Male? ☐ F-Z31.430 ☐ M-Z31.440

Is Patient or Patient's Partner Currently Pregnant? ☐ Yes Z33.1 ☐ No
If Yes, please specify Gestational Age: Weeks_____ Days_____

U/S Date: _____ **LMP Date:** _____

1st Trimester	2nd Trimester	3rd Trimester
☐ 1st Pregnancy Z34.01	☐ 1st Pregnancy Z34.02	☐ 1st Pregnancy Z34.03
☐ Other Pregnancy Z34.81	☐ Other Pregnancy Z34.82	☐ Other Pregnancy Z34.83

☐ Encounter for supervision of first normal pregnancy, unspecified trimester Z34.00
☐ Encounter for supervision of other normal pregnancy, unspecified trimester Z34.80

☐ No Family History	☐ Male or Female Infertility
☐ Patient Known Carrier**	☐ Family History of Consanguinity
☐ Partner Known Carrier*	☐ Egg or Sperm Donor
☐ Known Family History* (specify relationship)_____	☐ Abnormal Fetal Ultrasound (specify)_____

*FOR MALE PATIENTS

If partner had carrier screening done at Otogenetics, please provide name and date of birth or provide the below information and attach report, if applicable**

Please note for MALE partner screening due to positive findings in the female partner, the MALE partner test report will only include the gene(s) for which the female partner was positive, unless analysis of other gene(s) are requested.

Name of Partner	DOB
Disease	
Gene	Variant

10. PATIENT INFORMED CONSENT

I confirm that I have been informed about the details of the tests ordered for me by my provider that includes Otogenetics Carrier Screening Panels. I understand the risks, benefits and limitations of testing and I voluntarily consent to testing. I give permission to Otogenetics to perform the genetic tests described. I do hereby name Otogenetics Corporation located at 4553 Winters Chapel Road, Suite 100, Atlanta, GA 30360 to act as my Authorized Representative in requesting a prior authorization, appeal or documents from my health insurance carrier regarding the above-noted service or proposed service and to inform my health plan of my test result only if required for preauthorization or payment of additional reflex testing. I understand and agree that this authorization is voluntary, that my health information may contain information created by other persons or entities including healthcare providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDs, psychotherapy, reproductive, communicable disease and healthcare program information, that I may not be denied treatment, payment for health care services or enrollment or eligibility for healthcare benefits if I do not sign this from, that my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or healthcare provider, the information may no longer be protected by the federal privacy regulation. This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying my healthcare provider, Otogenetics, or my health insurance carrier in writing. However, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed. I authorize plan benefits to be payable to Otogenetics, for Otogenetics to contact me about my out of pocket responsibility. I understand I am financially responsible for services performed and for sending Otogenetics all of the money I receive directly from my health plan for this test. If both you and your partner are being tested simultaneously or if your results are subsequently merged, you are authorizing release of your results to your partner's healthcare provider, which may include sensitive information.

☐ **Optional**: I consent to use of my de-identified test samples for research.
☐ **Optional**: I consent to be contacted by Otogenetics for research opportunities.

Patient Signature _____ **Date** _____

11. CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

The tests ordered are medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine the patient's medical management and treatment decision. The person listed as the Ordering Physician is legally authorized to order the test(s) requested herein. The patient has received genetic counseling and was provided with information about the risks and benefits of genetic testing and has consented to genetic testing. Attestation of Genetic Counseling is on the reverse side of this form.

Ordering Physician Signature _____ **Date** _____

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DESIGNATION OF AUTHORIZED REPRESENTATIVE FORM

Member Name (please print)	Date of Birth	Member ID Number	
Member Street Address	**City**	**State**	**Phone**
Please use patient information found on the front side of this form or found on the attached patient demographic sheet			
Name of Company being designated as the Authorized Representative			
Otogenetics Corporation			
Authorized Representative Address	**City**	**State**	**Phone**
4553 Winters Chapel Road, suite 100	Atlanta	GA	855-686-4363
Provider of Service			
Otogenetics Corporation			
Date(s) of Service or Proposed Service			

I, _____, do hereby name Otogenetics Corporation to act
Print the name of the member who is receiving the service
as my Authorized Representative in requesting a prior authorization, appeal or documents from my health insurance carrier regarding the above-noted service or proposed service.

I understand and agree that:

- This authorization is voluntary.
- My health information may contain information created by other persons or entities including healthcare providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDs, psychotherapy, reproductive, communicable disease and healthcare program information.
- I may not be denied treatment, payment for health care services or enrollment or eligibility for healthcare benefits if I do not sign this from.
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or healthcare provider, the information may no longer be protected by the federal privacy regulation.
- This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying my healthcare provider, Otogenetics, or my health insurance carrier in writing. However, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Member	Date
If the person signing this authorization is not the Member, then describe the relationship to the Member (Parent, Legal Representative)	
Legal Representatives signing this authorization on behalf of a Member must furnish a copy of a health care power of attorney or other relevant documentation that grants the applicable legal authority.	

GENETIC COUNSELING ATTESTATION FORM
INDEPENDENT GENETIC CARE PROVIDER INFORMATION
I affirm that I am a healthcare provider and I am not employed by a commercial genetic testing lab. Genetic counseling has been performed with the indicated patient, including collection and assessment of attached documentation.
Genetic Counseling included discussion of the topics below:
Explaining genetic carrier screening
Dominant and recessive genes
The meaning of being a carrier
Carrier screening and ethnicity
Expanded carrier screening
Limitations and advantages of carrier screening
How carrier screening is done
Meaning of test results
Options for couples who find out that they are carriers
Advantages of early screening